DEPARTMENT OF THE ARMY
WALTER REED ARMY MEDICAL CENTER
6900 GEORGIA AVE N.W.
Washington, DC 20307-5000

WRAMC Regulation 3 JULY 2002
Number 40-614

Medical Services
INTERDISCIPLINARY DISCHARGE PLANNING PROGRAM

1. Purpose. To establish guidelines, standards, policies and procedures for continuing care/discharge planning services at Walter Reed Army Medical Center (WRAMC) and to identify the key staff members and their responsibilities for continuing care/discharge planning.

2. References.

a. AR 40-3, Medical, Dental, and Veterinary Care. 28 JAN 2002

b. AR 40-48 Non Physician Health Care Providers. 7 NOV 2000

c. WRAMC Regulation 40-104, Comprehensive Screening, Assessment and Reassessment of Patients. 1 JUN 2002

d. Comprehensive Accreditation Manual for Hospitals (CAMH), Joint Commission on Accreditation of Health Care Organizations (JCAHO).

3. Definitions.

a. Continuing Care – Assessment-based patient care provided over an extended time, integrated and coordinated among various settings, spanning the illness-to-wellness continuum. Continuing care activities include, but are not limited to, discharge planning.

b. Discharge Planning Services - Those processes designed to facilitate the smooth, safe and effective transition of inpatients from acute medical care at WRAMC to continuing care environments outside the hospital. All patients require some degree of discharge planning; however, this regulation applies primarily to patients requiring the extensive, coordinated efforts of a discharge planning team.

c. Interdisciplinary Discharge Planning Team – An interdisciplinary group of health care providers contributing to a continuing care plan.

d. Case Management - A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual’s health care needs and desires through communication and available resources to promote quality care and cost-effective outcomes.

4. Responsibilities.

a. All WRAMC Healthcare Staff.

(1) Identify continuing care needs based on initial and ongoing patient assessment.

(2) Work as an interdisciplinary team to meet identified patient needs.

(3) Assess patient/family for educational needs.

(4) Assist patients and/or significant others in gaining the knowledge and skills needed to meet the patient’s ongoing health care needs.

(5) Documents assessment/reassessment, intervention, education, continuing care needs and plans in appropriate records.

(6) Ensure that all appropriate discharge instructions are conveyed to the PCM, patient and/or significant other and to the agency (if applicable) responsible for the continuing care of the patient.

(7) Develop and maintain quality assessment and improvement process for continuing care activities.

(8) Identify appropriate patients for case management.

(9) As appointed by multidisciplinary committee, act as a WRAMC or shared case manager for selected patients.

b. Primary Care Manager (PCM).

(1) Bears primary responsibility for overall needs assessment, care management and planning for assigned patients.

(2) Identifies and addresses continuing care needs at every stage in the illness-to-wellness continuum and involves other members of the continuing care team as appropriate.

(3) Incorporates the discharge plan into the overall care plan and coordinates with involved service providers as appropriate.

(4) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

c. Ward/Specialty Care Physician Staff (inpatients and patients receiving specialty care services).

(1) Identify present and potential patients expected to require continuing care as early as possible and initiate appropriate consults/referrals.

(2) Coordinate with other members of the Discharge Planning Team regarding changes in a patient's condition, particularly nursing staff and medical social worker.

(3) Inform the social worker and nursing staff of patient’s readiness for discharge and schedule discharge dates as early as they are known.

(4) Attend interdisciplinary team meetings to consider and coordinate continuing care/discharge plans.

(5) Prescribe any medical or non-medical supplies and equipment patients will require upon transfer to another level of care.

(6) Ensure that patients' medical discharge summaries include instructions regarding physical activity, medications, diet and follow-up, as required.

(7) As appropriate, reevaluate patients during return clinic visits following discharge to ensure the adequacy of post-hospitalization care.

(8) When a patient will be referred to another agency for home health care, provide a written discharge summary and complete DA Form 4700 0verprint 161(Skilled Home Health Patient Referral) for the Discharge Planning Nurse to transmit to the home health agency.

(9) When a patient will be transferred to another facility, provide a written summary to the medical social worker for transmission to the gaining facility.

(10) Along with social work, nursing, and utilization management staff, identify complex/high-cost cases for referral to TRICARE or other external case managers or for ongoing WRAMC or shared case management.

(12) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

(13) Communicates discharge plans to PCM.

d. Deputy Commander for Nursing ensures that nursing staff comply with the following requirements:

(1) Within 24 hours of admission, through ongoing nursing assessment, identifies patients with possible continuing care needs and documents on the Nursing Admission Note in the Computerized Information System (CIS).

(2) In coordination with social work staff and other interdisciplinary team members, initiates appropriate discharge assessment, services, and planning.

(3) Observes patients and suggest revisions to continuing care/discharge plans to primary care physicians as changing patient conditions indicate.

(4) Convenes interdisciplinary team meetings to assist in the coordination of continuing care/discharge plans.

(5) Contributes to Interdisciplinary Discharge Plan.

(6) Provides patient and family member teaching as required.

(7) Provides patient nursing/healthcare requirements to internal and external agencies as needed.

(8) Along with social work, discharge planning, physician, and utilization management staff, identifies complex/high-cost cases for referral to TRICARE and other internal and/or external case managers or for ongoing case management.

(9) Document patients' discharge plan of care or progress toward discharge.

(10) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

e. Chief, Department of Social Work

(1) Assists physician, nursing staff and other members of the health care team to identify continuing care/discharge plans and to formulate appropriate goals and objectives.

(2) Conducts psychosocial assessment of patient's needs and the availability of resources necessary to effect a safe and adequate transfer from one level of care to another.

(3) Assesses patients' and families' coping abilities and styles, mental status, support systems, psychosocial strengths and weaknesses, adjustment to illness/trauma, motivation and ability to comply with and manage recommended treatment.

(4) Assists family members and patients to deal with social/emotional difficulties related to the patient's conditions and the requirements of the continuing care/discharge plan.

(5) Provides crisis intervention and therapeutic intervention to increase coping abilities, promote adjustment and manage and relieve emotional distress.

(6) Collaborates and coordinates with all health care providers, the patient, patient's family, and appropriate continuing care resources in order to create and implement appropriate plans for transfer to another level of care.

(7) Arranges, coordinates, conducts and participates in family conferences with the physician, interdisciplinary team members, and ancillary staff from the hospital and outside resource agencies involved in the continuing care/discharge plan. Ensure involvement of patient/family in the decision making process for timely discharge to appropriate level of care.

(8) Serves as liaison as needed to the civilian community and external case managers and acts as a referral source to the staff, the patient and his/her family.

(9) Coordinates with discharge planning and utilization management on all cases that require their involvement. Reports all Walter Reed Tricare PRIME placements to Chief, Care Continuum Management Service for case management.

(10) Works collaboratively as a team member with ward interdisciplinary team and case management. Attends and participate in assigned ward interdisciplinary team meetings.

(11) Provides support to staff in dealing with patients with catastrophic illness/injury.

(12) Facilitates problem solving and systems interventions between family members and between family members and staff.

(13) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

f. Chief, Department of Health Plan Management

(1) Provides information about the TRICARE program, to include the various TRICARE options available, the benefits of enrollment into TRICARE Prime or Plus, patient fiscal responsibilities, and claims assistance.

(2) Assists with the coordination of required health care services for active duty service members.

(3) Collaborates with social work, nursing, and physician staff to identify complex/high-cost patients for referral to TRICARE and other internal and/or external case managers for ongoing case management.

(4) Provides information about the benefits of enrollment in TRICARE Prime Provide information about cost sharing with the other Tricare options, Extra and Standard. Explain the role other health insurance, both primary and supplemental, has with all benefits

(5) Screens patients identified with discharge planning needs prior to and during hospitalization to ensure continuing care/discharge planning services are provided.

(6) Arranges for skilled nursing services (PT, OT, Oxygen, nursing, etc) for patients being discharged to home.

(7) Targets TRICARE PRIME, and other than Prime patients, complex, high-risk, or high-cost patients who require case management and coordinates their care to ensure the achievement of desirable patient outcomes, appropriate lengths of stay, efficient utilization of resources, increased patient and family involvement and patient/family education.

(8) Along with nursing, physician, and utilization management staff, identifies complex/high-cost cases that should be referred to TRICARE contractors and other internal and/or external case managers for ongoing case management.

(9) Along with the Patient Administration Division staff, provides statistical feedback to the command and departments on trends pertaining to admissions, length of stay (LOS), and diversions along with other reports.

(10) Pre-arranges specialty appointments for patients traveling from distant medical treatment facilities (CONUS) and outside the Continental United States (OCONUS).

(11) Works collaboratively as a team member with the ward interdisciplinary teams. Attends and participates in ward interdisciplinary team meetings.

(12) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

(13) Coordinates and chairs case management meetings.

g. Chief, Army Community Health Nursing

(1) Provides information to Social Work and other WRAMC health care professionals on available community resources for continuing care in the service area and skilled health nursing care in the service region.

(2) Provides telephone and/or home visits as staffing permits to patients to assess needs and to provide education to address concerns about medical condition and care.

(3) Provides educational programs for the military community to assist patients and their families in chronic disease prevention and health promotion.

(4) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

h. Chief, Physical Medicine and Rehabilitation and or Chief, Physical Therapy (PT).

(1) Restores patients to the highest possible functional level through an individually tailored rehabilitation program and appropriate use of assisting devices.

(2) Teaches patients to function as effectively and independently as possible within their limitations.

(3) Provides patient and family education regarding appropriate rehabilitation and use of prescribed equipment.

(4) Coordinates with the Continuing Care/Discharge Planning Team regarding special needs of patients.

(5) Provides information to the Continuing Care/Discharge Planning Team regarding patient's special community resource needs.

(6) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

(7) Attends interdisciplinary team meetings to consider and coordinate continuing care/discharge plans.

i. Chief, Physical Medicine and Rehabilitation and/or Chief, Occupational Therapy (OT).

(1) Provides screening and, if appropriate, functional assessment of patient's ability to perform critical tasks related to work, leisure, self-care, dressing, hygiene and feeding.

(2) Teaches and modifies activities of daily living to enhance physical and mental independence.

(3) Provides the patient with specific skills and supports to maximize level of safety, function, independence and quality of life while minimizing requirements for assistance, supervision and/or restrictions.

(4) Counsels families regarding patients' limitations and the prescribed rehabilitation program.

(5) Evaluates the family's ability and willingness to support the prescribed rehabilitation program.

(6) Prescribes non-medical self-care/activities of daily living (ADL) equipment needs.

(7) Provides information to the Continuing Care/Discharge Planning Team regarding special needs of patients.

(8) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

(9) Attends interdisciplinary team meetings to consider and coordinate continuing care/discharge plans.

j. Chief, Speech Pathology

(1) Restores patients to their highest possible functional level of communication and/or swallowing limitations through a vigorous rehabilitation program and appropriate use of assistive devices as needed.

(2) Teaches patients to function effectively and independently with their speech, language, voice and/or swallowing limitations.

(3) Provides patient and family education regarding appropriate rehabilitation, home activities and use of assistive devices.

(4) Provides information to the Continuing Care/Discharge Planning Team, regarding the patient's rehabilitation and community resources.

(5) Attends interdisciplinary team meetings to consider and coordinate continuing care/discharge plans.

(6) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

k. Chief, Department of Pharmacy.

(1) Ensures all patients receive medication counseling by pharmacy staff as pharmaceuticals are dispensed.

(2) Provides additional counseling by a pharmacist if required by a patient.

(3) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

l. Chief, Nutrition Care

(1) Evaluates patients' nutritional status based upon subjective and objective data.

(2) Evaluates ability and willingness of both patient and family to follow nutritional guidance.

(3) Educates patients and families on prescribed diets, meal planning and food/drug interaction as identified per SF 513 (Medical Record – Consultation Sheet) or by nutrition screening and assessment.

(4) Refers patients to the Wellness Center or dietitian on other specialty clinics for follow up consultation or to appropriate community agencies.

(5) For patients discharged to extended care facilities, the ward dietitian will be available to communicate nutrition needs per request (information provided on DA Form 3888-3 (Medical Record - Nursing Discharge Summary)).

(6) Provides information to the Continuing Care/Discharge Planning Team regarding special community resource needs for patients.

(7) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

m. Chief, Pastoral Care

(1) Visits inpatients identified as having continuing care needs to ascertain their desire for pastoral intervention and documents in inpatient record.

(2) Coordinates pastoral interventions within patients' communities.

(3) Assists Continued Care/Discharge Planning Team members in obtaining community resources.

(4) Documents assessment/reassessment, intervention, continuing care needs and plans in appropriate records.

n. Chief, Patient Administration Division.

(1) Upon request, provide:

(a) Records or statistical information to Social Work and/or other members of the Continuing Care Team.

(b) Technical assistance on Medical Board issues.

(c) Guidance on the payment of bills. Ensure WRAMC and patient understand payment/ co-payment responsibilities to contractor (if applicable) prior to discharge.

(d) Information reference patient transfers that require air evacuation through the Global Patient Regulating Center (GPRC).

(e) Assistance with the transfer of active duty patients to Veterans Administration hospitals, Armed Forces Retirement Home - Washington, and other facilities with which WRAMC has MOUs and MOAs.

(f) Administrative support to facilitate difficult transfers to another level of care and/or facility.

5. Policy and Procedures:

a. General. The continuing care/discharge planning program is based on initial and ongoing patient assessment. It provides a system for the early identification and evaluation of patients requiring continuing care services and ensures transitions between levels of care are smooth and safe. Additionally, the program ensures effective utilization of resources/levels of care by reducing hospital stays beyond the need for acute care and by systematically coordinating the services of all WRAMC agencies involved in continuing care/discharge planning.

b. Continuing Care. Continuing care needs may be identified during any patient assessment. The core location for interdisciplinary collaboration on outpatient cases is the primary care site. Depending on the nature of identified needs, such needs may be resolved with the current care provider, clinic nurse and/or case manager. Case managers are involved in a few cases with multiple and/or complex medical/social needs. Medical social work staff can provide consultation or assess and refer to appropriate agencies. Other WRAMC and external agency staff may be involved in interdisciplinary collaboration or referral for consultation and/or services as required.

c. Discharge Planning Screening. The discharge planning process begins on or before the first day of admission for all patients and continues beyond discharge as necessary. The admitting physician assesses all prospective inpatients. Surgical patients are screened during the pre-operative evaluations. Once a patient is admitted, nursing staff assess for continuing care needs as part of the initial nursing history and assessment. Additional patient continuing care/discharge planning needs are identified at daily physician rounds, daily nursing/social work rounds and continuing care or psychosocial support needs are referred to Social Work or Discharge Planning Nurse for assessment and discharge planning coordination. As necessary, consults are forwarded to other specialty services.

d. Coordination. Continuing care/discharge plans are made in coordination with the patient, family and interdisciplinary team. Generally, the attending physician, ward nursing staff, and social worker will be involved in all cases with significant continuing care/discharge planning needs. Case managers are involved in certain cases. Other involved health care providers, PCM, outpatient nursing staff and external agency staff will be included as appropriate. Coordination takes place throughout the day. Opportunities for more formal case discussions include daily rounds, interdisciplinary discharge planning meetings and scheduled case conferences.

e. Follow-Up. Upon discharge the patient is returned to the PCM for continued follow-up. Discharge planning, social work and nursing staff may make follow-up phone contacts with patients with complex situations or discharge plans as appropriate. Case managers from WRAMC staff or external agencies follow selected complex, high risk and/or high cost cases throughout the continuum of care.

The proponent agencies for this regulation are The Department of Social Work and Department of Health Plan Management. Users are invited to send comments or suggested improvements to the Chief, Department of Social Work.

FOR THE COMMANDER:

OFFICIAL:

JAMES R. GREENWOOD
COL, MS
Deputy Commander for
Administration

ERIK J. GLOVER
MAJ, MS
Executive Office

DISTRIBUTION:
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